FORM 112

APPLICATION FOR REIMBURSEMENT

Michigan Department of Consumer & Industry Services
Bureau of Workers' & Unemployment Compensation
Funds Administration
7201 W. Saginaw Hwy., Suite 110, Lansing, MI 48917

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FUNDS ADMINISTRATION	FUNDS ADMINISTRATION USE ONLY
1. Total & Permanent Disability Provision - Section 521 (1) (2) 2. 70% Reimbursement Provision - Section 862 3. Two Years of Continuous Disability Provision - Section 356 (1) 4. Vocationally Handicapped Provision - Section 925 5. Dual Employment Provision - Section 372 6. Silicosis, Dust Disease and Logging Industry Compensation Fund - Section 531	REQUEST NUMBER **Click here to start** CARRIER FILE NUMBER

COMPLETE THIS SECTION FOR ALL FUNDS

Applications for reimbursement should be submitted every six months unless otherwise indicated.

EMPLOYEE NAME (Last, First, Middle)	SOCIAL SECURITY #	INJURY DATE	BIRTH DATE

EMPLOYEE ADDRESS (Street No. and Name) (City) (State) (Zip) (Phone Number)

NAME OF EMPLOYER	EMPLOYER ADDRESS

INSURANCE CO. OR SELF-INSURED EMPLOYER	SERVICE COMPANY OR TPA (If Applicable)

FEDERAL I.D. NUMBER	CONTACT PERSON	TELEPHONE NUMBER

PAYMENT ADDRESS

Tax filing status at time of injury: Choose filing status
Claimant's Average Weekly Wage: $_____
Carrier/Employer Present Weekly Compensation Rate: $_____

Benefits calculated on a _____ day week
IS THERE A THIRD PARTY CLAIM? ☐ YES ☐ NO
If YES, provide pertinent information on claim.

DEPENDENTS Spouse _____

Children	Birth date

HAS BASIC BENEFIT CHANGED DURING PERIOD?
☐ YES ☐ NO Date of Benefit Change: _____ Attach 701 Reason for Change: ☐ Age Reduction ☐ Benefit Coordination ☐ Employment ☐ Dependency Change (attach verification) ☐ Unemployment Compensation ☐ Other _____

HAS EMPLOYEE BEEN GAINFULLY EMPLOYED DURING PERIOD COVERED BY THIS REIMBURSEMENT?
☐ YES Attach records confirming employment with evidence of weeks and hours worked, and earnings statement (Provide evidence on value of fringe benefits if applicable)
☐ NO Attach information received verifying continuing disability and current activities

(1) COMPLETE this section when requesting reimbursement from the Second Injury Fund **- TOTAL AND PERMANENT DISABILITY PROVISION:**
Weekly differential benefits paid on Fund's behalf:

_____ thru _____ , _____ weeks at $_____ = $_____

_____ thru _____ , _____ weeks at $_____ = $_____

TOTAL AMOUNT REQUESTED IN THIS REIMBURSEMENT $_____

(2) COMPLETE this section when requesting reimbursement from the Second Injury Fund **- 70% REIMBURSEMENT PROVISION:** (submit after all appeals are final)
(a) Decision by Board of Magistrates ordering payment and order reversing/modifying decision:
(b) Confirmation that ALL appeals are final ☐ YES ☐ NO
(c) Copy of all 701s indicating payments
(d) Written verification of dependents during appeal period

NOTE: Request reimbursement for medical expenses paid under section 862(2) by completing BWC form 271.

70% Benefits Paid on Appeal:

_____ thru _____ , _____ weeks at $_____ = $_____

_____ thru _____ , _____ weeks at $_____ = $_____

Total 70% Benefits Paid: $_____

Minus: Dollar Value of final award, including interest (if applicable): — $_____

TOTAL AMOUNT REQUESTED IN THIS REIMBURSEMENT $_____

(3) COMPLETE this section when requesting reimbursement from the Second Injury Fund - **TWO YEARS OF CONTINUOUS DISABILITY PROVISION** - Reimbursement due on a quarterly basis

Weekly benefit rate paid on Second Injury Fund's behalf:

_____ thru _____ , _____ weeks at $_____ = $_____
_____ thru _____ , _____ weeks at $_____ = $_____
TOTAL AMOUNT REQUESTED IN THIS REIMBURSEMENT $_____

(4) COMPLETE this section when requesting reimbursement from the Second Injury Fund **- VOCATIONALLY HANDICAPPED PROVISION** - Vocational rehabilitation benefits under section 319 are reimbursable from the date of injury

_____ thru _____ , _____ weeks at $_____ = $_____
_____ thru _____ , _____ weeks at $_____ = $_____
Total weekly benefits paid on Fund's behalf: $_____
Medical expenses paid during period (attach copies of bills and reports): $_____
Vocational rehabilitation costs paid during period (attach copies of bills and reports): $_____
TOTAL AMOUNT REQUESTED IN THIS REIMBURSEMENT $_____

(5) COMPLETE this section when requesting reimbursement from the Second Injury Fund - **DUAL EMPLOYMENT PROVISION** - Reimbursement due on a quarterly basis

NOTE: (1) Include forms 100 & 701. Attach WAGE RECORDS for all employers.
(2) Attach DOCUMENTATION OF DISABILITY, i.e., medical records.
(3) Complete only Section II on continuous reimbursement cases, otherwise, complete both.

INSTRUCTION FOR COMPLETION OF SECTION I:
(1) 3 or more employers? Use separate sheet to provide information (employer, address, wages) required
(2) Carry out apportionment percentages to one hundredths of a percentage (**xx.xx% or .xxxx**)
(3) Average weekly wage with each employer is based upon number of weeks worked at that employer

I. Name of Employer: Place of Injury

	WAGES	**NUMBER OF WEEKS USED**		**AVERAGE**
_____	$_____	÷ _____	=	$_____ (A)
Name of Other Employer				
_____	$_____	÷ _____	=	$_____
Address: _____			Total average weekly wages	
_____			From separate sheet (if applicable):	$_____
Phone: _____				$_____ (B)

Has there been a return to work with any employer ☐ YES ☐ NO Employer _____ Date: _____

If yes, complete section across: > Employer _____ Date: _____

Employer _____ Date: _____

II. Carrier/Employer Apportionment % of liability: $_____ (A) ÷ $_____ (B) = _____ (C)
Dual Employment Provision's % of liability: 100% - _____ (C) = _____ (D)

If (D) is less than 20%, the DUAL EMPLOYMENT PROVISION has no liability pursuant to Section 372.

Workers' Compensation Benefits paid during period:

_____ thru _____ , _____ weeks at $_____ = $_____

_____ thru _____ , _____ weeks at $_____ = $_____

Total weekly benefits paid during this reimbursement period: $_____ (E)

TOTAL AMOUNT REQUESTED IN THIS REIMBURSEMENT _____ (E) x _____ % (D) = $_____

(6) **COMPLETE** this section when requesting reimbursement from the **SILICOSIS & DUST DISEASE FUND or LOGGING INDUSTRY COMPENSATION FUND**

Weekly benefits paid during this period:

_____ thru _____ , _____ weeks at $_____ = $_____
_____ thru _____ , _____ weeks at $_____ = $_____
_____ thru _____ , _____ weeks at $_____ = $_____
Total benefits paid during period $_____
Minus threshold **on first reimbursement only** - _____
Apportionment percentage due (SDDF only): x _____ %
TOTAL AMOUNT REQUESTED IN THIS REIMBURSEMENT: $_____

SIGNATURE OF AUTHORIZED REPRESENTATIVE	TITLE	DATE SUBMITTED

Authority: Workers Disability Compensation Act R408.46
Completion: Voluntary
Penalty: None

The Department of Consumer & Industry Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc. under the American's with Disabilities Act, you may make your needs known to this agency.